

Consequences for Challenging Behaviors:
A Call to End All Practices That are Not Evidence-Based

A White Paper by
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Executive Summary

Originally focused on why the most severe forms of punishment (i.e., restraints and seclusion time out) need to be eliminated altogether, a thorough review of the literature resulted in a different conclusion. This conclusion was based primarily on two factors. First, there is sufficient evidence that punishment, for a variety of reasons, does not work. Second, there are sufficient *positive* approaches to challenging behavior – regardless of severity and/or the challenge presented to others – that can be used instead, even in the presence of imminent danger and emergencies,

The paper begins by defining terms such as punishment and aversives that are critical to the discussion, provides an overview of startling statistics, and describes current public policy initiatives at the national and state levels. These sections are followed by a comprehensive review of the literature on restraint, seclusion time out, aversives, and punishment in general. Each of these sections delves into how research that supports the use of these strategies fails to take into account the functional and/or communicative nature of challenging behaviors and, in so doing, fails to prevent subsequent incidents of challenging behavior. Rather, research that does take physiological, contextual, functional, and/or communicative purposes into account relies on manipulation of antecedents – i.e., what comes *before* challenging behaviors occur – to successfully support, reduce, eliminate, and/or teach alternative behaviors instead. The paper concludes with a brief overview of meaningful consequences for those who may still believe that refraining from punishment equates to “letting young people do whatever they want to do.”

As will be shown, no such equation exists.

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**Consequences for Challenging Behaviors:
Why Not Punish with Aversives Including Restraints and Seclusion Time Out?
A Call to End Archaic Practices That Are Not Evidence-Based**

Introduction

Despite the wealth of solid research providing alternatives for addressing challenging behaviors, “aversives” including restraint and seclusion time out are still being used in schools, by provider agencies, and in families today in an effort to control those behaviors. Those who do use these strategies often are under the impression that challenging behaviors need to be punished. They may believe that, the more severe the punishment, the less likely those behaviors are to reoccur. Others subscribe to a “spare the rod, spoil the child” way of thinking. Unfortunately, aversive punishments in particular are known to cause physical and psychological harm to those subjected to them. There are also well-researched principles about why challenging behaviors occur in the first place and the use of positive behavior supports which make these practices archaic and certainly not reflective of best practices.

This paper will first provide definitions of relevant terms used throughout it. Included in the definitions is a conversation about the inherently subjective nature of defining behaviors that could be considered challenging. Next, the paper describes the startling statistics of the use of restraints and seclusion time out in CT for what are considered emergencies “...to prevent immediate or imminent injury to the student or to others...” (P.A. 15-141 (Sec. 1(b) and (d))). Next, descriptions of how aversives including restraints and seclusion time out (A/R/S) have been used will be provided. Following this will be a summary of what the research says about punitive strategies and a discussion about why punishment in general does not have the intended effect on challenging behavior. The next to the last section will talk about why challenging behaviors occur and the last section will offer recommendations for evidence-based alternatives to punishment that would preclude the use of aversives, including restraints and seclusion.

1. Definitions

This section will first define punishment in general because this is often the popular rationale justifying the use of A/R/S, followed by what aversives, including restraints and seclusion time out are. Then behaviors will be defined to clarify what truly constitutes risk of immediate or imminent danger to an individual or others. The overall taxonomy of the techniques intended to control challenging behaviors are that punishments include aversives which include A/R/S.

Punishment

By definition, punishment is the introduction of an event (stimulus) after a behavior occurs (consequence) intended to reduce the probability that the behavior will recur (Azrin & Holz, 1966). By extension, consequences are only punishing if they a) follow the behavior and b) result in a decrease in the behavior. This decrease in behavior means that learning not to do the behavior has actually occurred. Because of numerous issues regarding the efficacy and ethics involved in the use of punishment (Reed & Lovett, 2007), CT is among a number of states that supposedly restricts use of more extreme forms of punishment such as restraint and seclusion time out to emergency situations in which there is immediate or imminent danger of harm to and individual or others. Note that the actual data, to be discussed in a subsequent section, suggests more widespread use (SDOE, 2016).

Imminent danger. Interestingly, Black’s On-Line Law Dictionary has only one entry on imminent danger and that is in relation to a defense for homicide:

In relation to homicide in self-defense, this term means immediate danger, such as must be instantly met, such as cannot be guarded against, in calling for the assistance of others or the protection of the law... Or, as otherwise defined, such an appearance of threatened and impending injury as would put a reasonable and prudent man to his instant defense.

Another online legal resource, U.S. Legal, adds:

“Imminent danger is an immediate threat of harm, which varies depending on the context in which it is used... Some (state) laws allow use of deadly force when imminent danger is present. Typical considerations to find imminent danger include the attacker’s apparent intent to cause great bodily injury or death, the device used by the attacker to cause great bodily injury or death, and the attacker’s opportunity and ability to use the means to cause great bodily injury of death.”

Despite these definitions, there is great inconsistency in how the “imminent danger” standard is applied by experts in both psychiatry and law regarding, e.g., civil commitment proceedings. It is such an inconsistency that led to outpatient treatment being court-ordered for 23-year-old Seung Hui Cho who, in 2007, killed 32 people and injured at least as many more in what has come to be called the “Virginia Tech Massacre” (Pfeffer, 2008).

Emergency. An emergency is generally defined as any circumstances in which there is imminent danger of harm to the person or others. As discussed in the previous discussion of “imminent danger” standards, it is difficult to further define “emergency.” What is essential for the purposes of this discussion is what Perske (1972) called “Dignity of Risk” and opined “Where many of us have worked overtime in past years to find clever ways of building the avoidance of risk ... now we should work equally hard to help find the proper amount of normal risk...” When applied to challenging behaviors, people with, for example, mental health problems and intellectual disabilities themselves report that the type of support they receive from, and quality of positive relationships that have with, caregivers across settings is often the major determinant of whether issues rise to the level of genuine emergencies (Venville, Sawyer, Long, Edwards, & Hair, 2015).

As will be discussed in subsequent sections of this paper, there are many strategies that can be used to de-escalate situations before any danger is imminent and truly constitutes an emergency. R/S/As, then, cannot be based on the possibility of an emergency developing.

Aversives

The American Association on Intellectual and Developmental Disabilities (AAIDD) uses the following descriptors to define “aversives.” Aversives are anything resulting in:

1. Obvious signs of physical pain experienced by the individual.
2. Potential or actual physical side effects, including tissue damage, physical illness, severe stress, and/or death.
3. Dehumanization of the individual, through means such as social degradation, social isolation, verbal abuse, techniques inappropriate for the individual’s age, and treatment out of proportion to the target behavior. Such dehumanization is equally unacceptable whether or not an individual has a disability (AAIDD, 2012).

The Connecticut Department of Developmental Services (DDS) defines “aversive procedures” as:

“...the contingent use of an event or a device which may be unpleasant, noxious, or otherwise cause discomfort for an individual to (A) alter the occurrence of a

specific behavior, or (B) protect the individual from harming himself or another person. Aversive procedures may include the use of physical isolation, mechanical restraint, physical restraint, chemical restraint, or other department approved methods in accordance with sections 17a-238-7 to 17a-238-13, inclusive, of the Regulations of Connecticut State Agencies.” (DDS, 2018, pp. 1-2)

Aversives may include electric shock, loud noise, a reprimand, over-correction, response cost, visual screening, or the removal of a reinforcing stimulus such as food, money, or access to the social environment.

Some techniques used by occupational therapists involving deep pressure may result in obvious signs of physical pain (or at least discomfort) for some people but not others. For individuals with autism, however, research suggests that deep pressure can have reinforcing or calming effects (McGinnis, Blakely, Harvey, Hodges, & Rickards, 2013). The pressure is not experienced as painful and is therefore exempted from the definition of aversives.

Restraints. The CT Department of Developmental Services (DDS) defines three (3) types of restraint. These definitions appear in *Figure 1*.

Figure 1

CT Department of Developmental Services Definitions of Restraints

“Chemical restraint” means psychiatric medication administered on an emergency basis to an individual, who is in danger of harming himself or herself or another person, when all other interventions have failed. Medications used for pre-sedation for medical or dental procedures are not considered to be chemical restraints. (p. 2)

“Mechanical restraint” means an apparatus used to restrict an individual’s movement, including any device, such as helmets, mitts or bedrails, used to prevent self-injury. Devices designed by a physical therapist and approved by a physician that are used to achieve proper body alignment or balance, and protective devices approved by a physician to address an individual’s medical condition are not mechanical restraints. (p.3)

“Physical restraint” means a department-approved physical intervention used to restrict an individual’s movement to protect the individual or to prevent self-injury or injury to another person. (p.3)

SOURCE: Online Policy Manual (2018). Positive Behavior Support Program and Behavior Support Plans. Procedure No: I.E.PR.003. Hartford: author. Retrieved from <https://portal.ct.gov/DDS/PoliciesProcedures/DDS-Manual/DDS-Manual>.

The “Guidance Related to Recent Legislation Regarding Restraint and Seclusion in Schools” that were revised by the SDOE in July of 2018 added a new definition: “...any mechanical or personal restriction that reduces the free movement of a person’s arms, legs, or head, including but not limited to carrying or forcibly moving a person from one location to another” and specifically prohibits life-threatening physical restraint, use of

pharmacological agents, (SDOE, 2018).” Exempted from these definitions are brief contact to calm or comfort a student, minimal contact needed to escort a student safely from one area to another, medical devices used for positioning or to prevent injury from falls, and devices (e.g., helmets or mitts) used in accordance with a documented treatment plan as the least restrictive means of preventing self-injury (SDOE, 2018).

Each of these exemptions may be problematic if a child is resisting the physical contact or otherwise protesting it, and if she or he is immobilized in order to control problem behaviors, because “restraint is evident...” (Dunlap, Ostry & Fox, 2011). Mechanical restraints include chairs and other devices into which children are secured using duct tape, bungee cords, ties, and rope to restrain their movements (Butler, 2015) or belts, special sheets, wrist straps, chair ties, locked trays, or positioning in deep or overturned chairs preventing the individual from standing up (Sullivan-Marx, 1995). Physical restraints may include basket holds and 2- or 4-point prone restraints (Dunlap, Ostry & Fox, 2011), or martial arts-type hold that essentially handcuff the student (Butler, 2015). Although teaching martial arts to violent students has been shown to have a positive impact on reducing violent behaviors (Harwood, Lavidor, & Rassovsky, 2017), these techniques may be administered with force and in such a manner as to impair breathing (Butler, 2015). A number of reports cite staff lying or sitting on a student such that the adult’s weight renders the child immobile and causes bruising if not broken ribs (USGAO, 2009).

What restraint is not. Despite being a proponent of properly used restraints to protect children from harm due to violent behavior, Ziegler (2004) provides a good distinction between physical restraint and other forms of physical holding:

“It is important to clarify the interchangeable terms therapeutic holding and physical restraint. This physical intervention is when a trained adult stops a child from hurting self or others by using approved crisis intervention holds to protect the child until the child is no longer a danger. There are a variety of approved holds but all of them restrain the child from being violent and causing damage to self or others. A distinction must be made between the type of holding discussed in this article and “holding therapy,” which is a physically intrusive method to produce a crisis in a child and force the child to experience physical or psychological pain. Holding therapy and other similar intrusive techniques are not sanctioned by any legitimate professional organization and in the opinion of the authors are not therapeutic and are not valid psychological treatment.” (Ziegler, 2004)

“Response interruption” has been interpreted by some ABA practitioners to mean restraining, however briefly, the individual to interrupt their behavior (Cassella, Sidener, Sidener, & Progar, 2011; Konarski & Johnson, 1989). Non-aversive means of interrupting responses, which have been well documented (c.f. Miguel, Clark, Tereshko, Ahearn, & Zarcone, 2009), include such strategies as calling the individual’s name or making a loud exclamation (e.g., “Oh! Look!”) while simultaneously redirecting the individual to another engaging activity (RIRD) are excluded from this definition, though. Also excluded from the definitions of restraints are such self-restraints as holding onto others or other’s clothing, holding or squeezing objects, wrapping oneself in one’s own clothing or holding onto one’s own clothing, choosing to wear a particular item of clothing that restricts movement, clasping one’s own hands together, or wrapping one’s arms around oneself (Hyman, Oliver, & Hall, 2002) and voluntary use of a body sock (Lang et al, 2012) or weighted vest (Case-Smith, Weaver, & Fristad, 2015) for the purposes of providing sensory integration support.

Seclusion Time Out. The therapeutic benefit of seclusion initially was as a form of Time Out from Positive Reinforcement (TOPR) intended to prevent an individual's problem behavior from being inadvertently positively reinforced by events going on in the general environment. Dunlap, Ostry & Fox (2011) define seclusion as:

“... the involuntary confinement of a child alone in a room or isolated area from which the child is prevented from leaving. Seclusion may include having a door locked or blocked with the child being alone, or having a child placed away from peers and caregivers for a period of time with no access to social interaction or social activities... Seclusion (involuntary confinement) is an extreme procedure that is not developmentally appropriate and should serve no purpose as an intervention with young children. In the authors' opinion, young children must never be alone in a room or isolated completely from social interaction. (Dunlap, Ostry & Fox, 2011)

These authors distinguish STO from what this author refers to as “time away” as follows:

Seclusion can be confused with “time out” (as in “closed door time out”), however time out is defined simply as an intervention that involves removing or limiting the amount of reinforcement or attention that is available to a child for a brief period of time. Time out can be used as a component of an approved behavior support plan when it involves removing a child from an activity, taking materials or interactions away, or having the child sit out of an activity away from attention or interactions. It is important to emphasize that time out does not require or imply seclusion.” (Dunlap, Ostry & Fox, 2011)

Consistent with this view, the Georgia state law prohibiting the use of seclusion in public schools distinguishes between “...a student-requested break in a different location (160-5-1.35(1)(e))” and “behavioral intervention in which the student is temporarily removed from the learning activity but in which the student is not confined (160-5-1.35(1)(g))” (O.C.G.A. §20-2-240, 2010).

The extremes. In one situation, photos of the time-out room used “...was small—approximately the length of an adult's arm span— and was lined with ripped and dirty padding. In addition, the student's mother reported that the room lacked ventilation and had an odor of “dirty feet and urine” (USGAO, 2009). Unfortunately, as indicated by the startling statistics described in the next section, any of the above strategies intended to manage challenging behaviors can be misused by staff who are untrained or uncaring about the other consequences of their actions.

2. Defining Challenging Behaviors

Behavior can be loosely defined as “anything a dead person can't do” even though this definition has been called into question (Critchfield, 2017). Behaviors typically associated with the application of A/R/S's are thought to be severe in terms of potentially resulting, or actually having resulted, in harm to the individual, others, or property. They also, according to multiple CT laws and resulting regulations, must reflect risk of immediate or imminent harm to the individual or others. However, the severity, intensity, and duration of behavior often are “in the eyes of the beholder” in addition to be situational. Even so, a problem remains in that A/R/S are used “often in cases where they (the subjects of these procedures) were not physically aggressive and their parents did not give consent” (U.S. General Accounting Office, 2009).

Severe behaviors. Severe behaviors include those that are dangerous to oneself or others, damaging to property, health- or even life-threatening, and/or illegal. In everyday contexts, the following behaviors would fall into this category:

- Holds cutting knife by the handle with the knife point facing neighboring student (using a weapon)
- Repeatedly exposes private body parts and touches them during school hours (repeated indecent exposure becomes a felony)
- Says “I’m going to kill you” to a teacher (threat of violence)
- Brings brother’s gun to school (possession of a deadly weapon)
- Throws a desk onto the floor (destruction of public property)
- Gives an unrequited kiss to a neighboring student (sexual assault).

Context counts. One of the challenges with identifying whether these behaviors are actually intentional or not. What if the student holding the knife is actually learning to cut food? What if the exposure occurs during a trip to the bathroom? What if the comment made to the teacher is because the teacher said something outrageously funny and the student makes this statement while doubled over with laughter? What if the gun is an unloaded musket handed down for generations that an innocent student brought in while the class was studying the Revolutionary War? What if the unrequited kiss was not a kiss at all but rather a kindergartner with cerebral palsy who accidentally tipped into the lap of a neighboring female student during story time?

For a behavior to be considered “severe,” then, we have to look at the context. In these cases, context includes the probability of the actual outcome meeting the criteria of danger, damage, threat, or legality. We also need to be sure to include these criteria when describing such behaviors.

Behaviors that are seriously disruptive. These behaviors disrupt one’s own or others’ learning or may be harmful to individual’s or others health or well-being without being life-threatening or illegal. Sample behavior plans that I have reviewed over the years have included the following behaviors in this category:

- Yells loudly in class
- Walks around the room while everyone else is sitting down and working
- Sits in the hallway and does not get up to move with the rest of the class
- Fools around with friends
- Does not complete homework on time

As with behaviors described in the previous section, context counts as does the severity, intensity and duration of these events. Yelling because you stubbed your toe, walking around with teacher permission to sharpen your pencil, sitting in the hallway to complete an assigned project that the other students have completed already, interacting at recess, and not handing in homework surely do not rise to the same level of severity of threats or actual acts of violence, law-breaking, or possession of illegal items and, for most students, such behaviors are easily remedied with a stern look or comment. Unfortunately, students who have social-emotional disorders, autism, social pragmatic disorders, learning disabilities, and other forms of eligibility for special education services under the Individuals with Disabilities Education Improvement Act (IDEA, 2004) are most likely to be repeat offenders in this category of behavior.

Mild to moderately disruptive behaviors. These behaviors are not harmful to the individual’s or others’ health or well-being but definitely impacts on their or others’ availability for learning. From my own experience, the following behaviors have often been the target of behavior plans:

- Taps pencil on desktop
- Puts crayon in mouth
- Rocks back and forth in chair
- Looks away while the teacher is talking
- Talks while the teacher is talking
- Does not complete homework on time

Unfortunately, some individuals interpret these behaviors as having the same weight as severe behaviors and, even when initial consequences may be minor (e.g., scolding, redirecting), these sometimes result in restraint, seclusion time out or application of other aversives because the initial attempts don't change the behaviors.

National Case Studies. In ten case studies analyzed by the U.S. General Accounting Office (USGAO, 2009), use of R/S were documented in *nine* situations for the following minor behaviors that did not qualify as situations in which there was imminent danger of severe harm to the individual or others. Those marked with (*) resulted in death of a child.

- Not staying seated (two instances)*
- Had a seizure, lost control of his extremities and bladder and later became uncooperative*
- "uncooperative"
- Wandering
- Refused to work, wiggled a loose tooth
- Whistling, slouching, and hand-waving
- "Misbehavior"
- Not returning to the group after an activity
- Refusal to take a shower
- Refusing to push back his sweatshirt hood so staff could see his face (USGAO, 2009).

The consequences for these behaviors included prone restraint with an adult lying on top of the student, an adult sitting on top of the student, denial of medical attention for the seizure and prone restraint, restrained in a chair with multiple leather straps that resembled 'a miniature electric chair,' strapped to a cot while wearing a five-pound therapy vest ("sometimes so tightly that a teacher's aide would spend 5 minutes or more trying to unravel the knots"), denied lunch, smearing lunch over the student's face and in her hair, waving scissors at the child, slapped, hit with a flyswatter and ruler, restrained in a chair with masking tape and having his mouth taped shut, gagged and duct-taped to the desk, and unspecified "abuse." In three other situations where there was "imminent danger," staff consequence an initial behavior that seemed relatively insignificant appeared to lead to escalation (USGAO, 2009).

What is onerous is that we have absolutely no idea the extent to which some of these practices may be used in CT.

Clearly, the extreme measures some adults will take to address behaviors that are only mildly to moderately disruptive and staff require more training than "how to restrain." What we do not know from the available reports among CT educational and human services agencies is the extent to which A/R/S are used in this state for behaviors that do not place the individual and/or others at immediate or imminent risk of injury, to what level the risk of injury must rise, and whether the injury must be physical, traumatic, or a combination of the two.

3. Startling Statistics

CT has a Restraint and Seclusion Prevention Initiative Partnership established as a result of a 2015 report by the CT Office of the Child Advocate (Eagan, Kramer, & Cambria, 2015). This partnership consists of the following entities:

- Connecticut Council on Developmental Disabilities (CDD)
- Connecticut Judicial Branch Court Support Service Division (CSSD)
- Department of Children and Families (DCF)
- Department of Correction (DOC)
- Department of Developmental Services (DDS)
- Department of Mental Health and Addiction Services (DMHAS)
- Department of Public Health (DPH)
- Individuals with Lived Experience
- National Alliance on Mental Illness, Connecticut (NAMI-CT)
- Office of the Child Advocate (OCA)
- Office of Early Childhood (OEC)
- Office of Protection and Advocacy (OPA)
- State Department of Education (SDE)
- University of Connecticut Center for Excellence in Developmental Disabilities (UCEDD) (CT Clearinghouse, 2016-2019)

According to its website, “These partners support the vision, guiding principles and the overall goals of the initiative to prevent the use of restraint and seclusion in service environments across the life span” (CT Clearinghouse, 2016-2019). Five statewide conferences intended to raise awareness and develop skills across the state in alternatives to aversives including restraints and seclusion time out have been held to date.

Yet, according to several recent federal and state documents on the specific use of restraints and seclusion time out across the age span, the following data have been reported:

- From 4.0 to 12.5%¹ of CT’s 229 nursing homes were cited in 2014 by the Centers for Medicaid and Medicare Services for use of restraints (CMS, 2015, p. 134)
- Between 2003 and 2005, the costs of using restraints in psychiatric facilities nationwide decreased 92% from \$1,446,740 to \$117,036 (Lebel & Goldstein, 2005).
- An April 22, 2019, a search of the reports on the CT Department of Children and Family’s (DCF) website (<https://portal.ct.gov/DCF/Data-Connect/DCF-Data-Reports>) yielded to results to the keyword “restraint.” Included in the posted list of reports were those made to the CT Legislature as well as those related to children’s behavioral health.
- It does not appear that the CT Department of Mental Health and Addiction Services (DMHAS) requires reporting of use of aversives in its Quality Provider Reports. <https://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=489554>
- Restraint and seclusion is not mentioned in the CT Department of Developmental Services (DDS) 5-year plan (2017-2022) except to state that DDS participates in the partnership and has provided training in positive behavior supports to the CT DCF. No deaths are attributed to A/R/S in the DDS Mortality Report for 2017.

Perhaps most onerous is how children in CT are subjected to A/R/S. Statistics from the CT State Department of Education’s (CSDE) *Annual Report of the Use of Physical Restraint and Seclusion in CT, School Year 2016*, are as follows:

¹ Range reflects size of facility from <50 to >199 beds

- A total of 37,929 incidents of restraint and seclusion were reported involving an unduplicated count of 2,995 students. Thus, these students averaged nearly 13 incidents each.
- Despite the definition of when A/R/S is allowable, almost two per cent did not involve emergencies,
- Males represented 82.7% of those restrained or secluded.
- Almost half (49.6%) were white, 28.7% were Hispanic/Latino of any race, and 16.1% were Black or African American.
- Some students in preschool were restrained and/or secluded.
- The highest number of students restrained or secluded were in 1st through 5th grades, accounting for almost half of reported incidents.
- For each of these grades, increases in incidents were reported since the first year of data collection (2013-2014) which is attributed to greater clarity in reporting requirements. Decreases were reported for grades 6 thru 12.
- Injury occurred in 213 incidents with seven (7) of these, all resulting from use of restraints, meeting the criteria for “serious injury” (i.e., medical attention beyond basic first aid).
- IEPs of 71 students called for the use of seclusion time out resulting in a total of 681 incidents.
- The greatest number of incidents (11,122) occurred in approved private special education programs. The next greatest number occurred in public schools (7,411) followed by Regional Education Service Centers (2,162). Charter schools accounted for the remaining 31 incidents of restraint.
- Almost 60% of the incidents of restraint lasted 5 minutes or less. Over a third (38.3%) lasted from 6 to 20 minutes. Thirty-two incidents of restraint lasted over an hour.
- In comparison, one-third of the seclusion incidents lasted (33.0%) lasted 5 minutes or less. Almost half (47.1%) lasted from 6 to 20 minutes. Incidents of seclusion lasting over 60 minutes occurred 417 times. Of these, 10 incidents had been approved in the student’s IEP.
- A third of the incidents involved students with autism, 29.3% involved students with “Other Health Impairments,” and one fourth (25.4%) involved students with labels of Emotional Disturbance. (CSDE, SY 2016-2017).

This detailed level of reporting was required by C.G.S. Section 10-236b which, as can be seen, may have reduced the incidents of aversives but done so without having a significant impact on the frequency with which they continue to be used.

Furthermore, the figure of “37,929 incidents of restraint and seclusion were reported involving an unduplicated count of 2,995 students” in the 2016 School Year in CT (SDOE, 2016) is even more startling given that only some 18,000 were reported by CSDE to the Office of Legislative Research (OLR) as preliminary data for the 2011 school year (Moran, 2012). The mechanism for collecting data has subsequently been revised by the SDOE but the answer as to whether this represents an increase or decrease in use remains unanswered. Furthermore, no data at all is collected on other forms of aversives that may be used either sporadically or on a regular basis – e.g., denial of food, slaps or pinches by staff, verbally or emotionally abusive treatment, etc.

Current Statutes Concerning A/R/S

Public Policy Initiatives

In May of 2012, the U.S. Department of Education (USDOE) released a document containing fifteen principles intended to significantly reduce, if not eliminate, the use of R/S. These fifteen principles are:

1. Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.
2. Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional).
3. Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.
4. Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.
5. Any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse.
6. Restraint or seclusion should never be used as punishment or discipline (e.g., placing in seclusion for out-of-seat behavior), as a means of coercion or retaliation, or as a convenience.
7. Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child.
8. The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, revision of strategies currently in place to address dangerous behavior; if positive behavioral strategies are not in place, staff should consider developing them.
9. Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.
10. Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion.
11. Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel.
12. Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable Federal, State, or local laws.
13. Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.
14. Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.
15. Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and

other personnel to understand and implement the preceding principles. (USDOE, 2012)

At that time, as depicted in *Figure 2*, a number of federal initiatives were underway to address the use of A/R/S in order to make schools and treatment programs safe and welcoming to all.

Figure 2

Federal Involvement in Efforts to Reduce, if not entirely eliminate, A/R/Ss

U.S. Department of Education

- Letters from then Secretary of Education, Arne Duncan
- Review of State Policies and Procedures conducted by the USDO Regional Comprehensive Technical Assistance Centers
- National data collection by the USDOE Office for Civil Rights
- Establishment of the Technical Assistance Center on Positive Behavioral Interventions and Supports funded by the USDOE Office of Special Education Programs (School-wide Positive Behavioral Interventions and Supports or SWPBIS)

U.S. Department of Health and Human Services

- Regulations under the Children's Health Act of 2000 under Title V of the Public Health Service Act which stipulate that (1) restraint and seclusion are crisis response interventions and may not be used except to ensure immediate physical safety and only after less restrictive interventions have been found to be ineffective; (2) restraint and seclusion may not be used for discipline or convenience; (3) mechanical restraints are prohibited; (4) restraint or seclusion may be imposed only by individuals trained and certified in their application; and (5) children being restrained or secluded must be continuously monitored during the procedure.
- Centers for Medicare and Medicaid Services (CMS) issued regulations setting forth patient rights to be free of medically unnecessary restraint and seclusion in several types of health care facilities and programs, including: hospitals, in a final rule published at 71 Fed. Reg. 71378 (Dec. 8, 2006) that also applies to critical access hospitals; hospices, in a final rule published at 73 Fed. Reg. 32088 (June 5, 2008); Medicaid managed care, in a final rule published at 67 Fed. Reg. 40989 (June 14, 2002); programs of all-inclusive care for the elderly (PACE), in a final rule published at 71 Fed. Reg. 71244 (Dec. 8, 2006); and psychiatric residential treatment facilities for individuals under age 21, in an interim final rule published at 66 Fed. Reg. 7148 (Jan. 22, 2001). CMS has also proposed regulations governing the use of restraint and seclusion in Community Mental Health Centers, at 76 Fed. Reg. 35684 (June 17, 2011).

U.S. Department of Substance Abuse and Mental Health Services

- Six Core Strategies Model
- Six Core Strategies Training Curriculum to Reduce the Use of Seclusion and Restraint in Inpatient Facilities

SOURCE: U.S. Department of Education (2012). Restraint and Seclusion: Resource Document. Washington, D.C.: author.

The Six Core Strategies Model mentioned above was adopted by the National Association of State Mental Health Program Directors (NASMHPD) and included

summaries of the six strategies, a planning tool, and examples of debriefing policies and procedures (NASMHPD, 2008).

Despite these initiatives, a 2014 majority report from the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, found that "...federal regulations govern the use of seclusion and restraints in virtually every type of institution, including hospitals, nursing homes, and psychiatric facilities, but none apply to schools." (p. 11) Yet, "...the first round of data collected by the United States Department of Education in 2009-2010 demonstrated that these same practices that are prohibited in other settings were used in U.S. schools at least 66,000 times in a single school year. Because fifteen percent of school districts failed to report data, however, this figure likely underestimates use of seclusion and restraints." (p.3). In CT alone, reported uses from the 2009-2010 school year reported to the federal Department of Education's Office of Civil Rights, responsible for collecting state data about 6,000 uses of seclusion or restraints as compared to the 18,000 incidents reported to the state's DOE (p. 13-14).

Connecticut was one of the ten states that the committee focused on in developing its report. As a result of research into ten specific situations, the following common themes emerged:

1. There is a lack of parental notification when such procedures are used on their children and, despite IDEA provisions that parents are "equal members of the PPT (Hart & Zucker, 2015),"² parents have limited access to school records and reliable data to document the use of seclusion and restraints. This is especially onerous when the students subjected to these practices cannot adequately convey their experience including any pain or suffering endured. Further, parents often are unaware of the type of room being used for STO with reports ranging from concrete walls to small closed areas with blue mats on the walls to storage closets.
2. There are legal hurdles involved in filing and bringing a case to trial. Sometimes, a complaint filed by the parents with the state's Protection and Advocacy Agency (Disability Rights CT) may result in cessation of the use of these procedures but there is no clear path for parents when schools refuse to do so. Attempts to file for due process under the IDEA, sue for damages, or seek other relief under such laws as Section 405 of the federal Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, or the U.S. Constitution itself, may require that the child remain in the abusive environment in order for their case to even be considered. When cases have been addressed, parents may not prevail even when a death has occurred.
3. It is difficult to prove the existence of psychological harm. Both criminal and civil courts do not weigh claims of this as heavily as clear signs of physical abuse. Teachers have been given leeway for their claim that application of the procedures confers some sort of educational benefit.
4. There is deference afforded to school personnel in decision-making about application of these procedures as well as a tendency for schools to adopt a "code of silence" at the first sign of trouble with a parent. Schools may or may not mention the use of these procedures in PPT meetings and may not commit to maintain

² Although the actual language of the IDEA § 300.322 regarding Parent participation only speaks to the obligations of a school district in assuring the *participation* of parents in IEP meetings, this provision has been widely interpreted to mean that parents are equal members of the PPT (PACER Center, Inc., 2015) and that the due process provisions of the IDEA (C.F.R. §300.501 through §300.520) were intended to "level the playing field" to assure that equality (PACER Center, Inc., 2015).

appropriate documentation. Teachers may be afforded the same status and presumption of greater experience and expertise than parents even by parents – in much the same manner as doctors and lawyers may be.

5. Existing remedies to fail to offer adequate relief because they are time-consuming and expensive. It may be years before a case is heard by an appropriate authority and, to prevail, families need to bare the added costs of attorney and expert witness fees, even if these fees are ultimately reimbursed. State departments seldom have the resources or even the expertise – e.g., in the CT Departments of Children and Families -- to address these issues. (HELP, 20014). Even when remedies are court-ordered, there is no real oversight to assure that these are appropriately implemented.

The summary for CT yielded the information contained in *Figure 3*.

Figure 3

Summary of CT's Status in the 2014 Majority HELP Committee Report

Location and Victim

- Connecticut public school
- Multiple grade-school children with disabilities

Description of Incident

- Teachers isolated “disruptive” children closet-sized “scream rooms” with concrete walls.
- Other children complained of hearing loud noises and cries coming from the rooms.
- Building custodians reported having to clean up blood and urine from the floors and walls.

Outcome and Other Developments

- Media coverage prompted various investigations by state agencies and a new state law. The school took corrective actions as a result.
- Subsequent to enactment of the state law, a parent told the Committee staff she sent her daughter to private school after a public school repeatedly secluded her daughter in a cell-like room.

Source: U.S. Senate Health, Education, Labor, and Pensions Committee (2014). Majority Committee Staff Report: Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases. Washington, D.C.: author.

The CT press covered the use of “scream rooms” in the Middletown School District after parents of students in general education reported their children’s distress over hearing sounds from children secluded in these barren areas (NBCConnecticut.com, 2012; WFSB Staff, 2012). As a result of public outcry, the use of this aversive strategy was terminated by the district but there are no records of how many students were subjected to trauma from being placed in these rooms for their behavior or traumatized by listening to schoolmates’ voices. The Department of Children and Families (DCF) actually cleared administrators of charges of abuse or neglect related to the incidents despite the fact that many of the students subjected to this treatment were actually under the care and custody of the CT Commissioner of DCF (McGaughey & Bell, 2013). The question then is, what else is being done by way of these extremes that are not, as of yet, reported?

Connecticut Statutes, Regulations, Policies, and Guidance Documents

CT has several laws in its General Statutes concerning the use of A/R/S. The address separate state agencies including the CT Board and Department of Education, Department of Children and Families, Department of Corrections, Department of Developmental Services, and the Department of Mental Health and Addiction Services.

As can be seen, there is yet to be an overriding state policy enacted in statute and codified in regulations that applies to all CT citizen.

CT Board and Department of Education. Statutes, regulations, and guidance documents exist in CT pertaining to A/R/S in public schools.

- The state Board of Education is responsible for regulating, among other topics related to schooling in CT, “...the use of physical restraint and seclusion pursuant to section 10-236b...” (C.G.S. Sec. 10-76b(a)) As a result of this statute, the SDOE has issued guidance to schools (both public and approved private) which specifically prohibits life-threatening physical restraint, use of pharmacological agents, and use of other physical restraints or seclusion except in emergencies involving imminent danger of harm to the student or others (SDOE, 2018)

- “(F) At each initial planning and placement team meeting for a child or pupil, the responsible local or regional board of education shall inform the parent, guardian, surrogate parent or pupil of the laws relating to physical restraint and seclusion pursuant to section 10-236b and the rights of such parent, guardian, surrogate parent or pupil under such laws and the regulations adopted by the State Board of Education relating to physical restraint and seclusion.” (C.G.S. Sec. 10-76b(a)(10)(F))
- None of these procedures can be used in a “planned intervention” (SDOE, 2016). This statement supplants the previous practice that such procedures could be used as long as their use is approved by a PPT and stated in the IEP (C.G.S. Sec. 10-76b(a)(10)(F)). However, other statements in this document defining where seclusion can take place, required documentation of incidents, requirements that students for whom these techniques are applied “in an emergency” be continually monitored, a provision for an administrator to determine whether continuation of the technique is necessary to prevent imminent danger, required reporting of injuries, and when repeated use must be reviewed all imply to school districts that such techniques continue to be acceptable and perhaps more at the discretion of staff whose definitions of emergencies may vary greatly.
- In contrast, Georgia, a state generally considered to have less resources for student education, has prohibited the use of prone restraint, mechanical restraint, chemical restraints, and seclusion in its public schools and educational programs since 2010 (O.C.G.A. §20-2-240). Instead, Georgia requires comprehensive training in non-violent Crisis Intervention in the event that physical restraint must be used only as an absolutely “... last resort when an individual is an immediate danger to self or others and other less restrictive interventions have been tried and have failed (emphasis added, crisisprevention.com, 2010).”

CT Department of Children and Families. This mission statement of DCF is “Working together with families and communities for children who are healthy, safe, smart and strong.” Nowhere in its “seven cross-cutting themes” are abuse and neglect, or A/R/S, specifically mentioned (DCF, 2019). Further, definitions of abuse and neglect do not specifically address the possible role of A/R/S in causing harm to children.

- DCF was required to develop a comprehensive implementation plan, across agency and policy areas, for maintaining records on the use of restraints (C.G.S. Sec. 17a-22bb(a)(1)) and to report biennially through 2019 on the status of implementation (C.G.S. Sec. 17a-22bb(a)(4)).
- Among the rights of children under the supervision of the DCF Commissioner are to be covered by regulations addressing “When a child or youth may be placed in restraint or seclusion or when force may be used upon a child or youth (Sec. 17a-16(d)(1))” and to have “...a copy of any order placing a child or youth in restraint or seclusion in accordance with the regulations adopted in subdivision (1) of this subsection ... made a part of the child's or youth's permanent clinical record,” (Sec. 17a-16(d)(2)),”

Department of Corrections. The Commissioner of Correction must maintain “... records regarding the frequency and use of physical restraint and seclusion, as defined in section 46a-150, on children and youth twenty years of age or younger who are in the custody of the commissioner at the John R. Manson Youth Institution, Cheshire, and shall submit a report summarizing such records, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children. Such report shall address the prior year and

shall indicate, at a minimum, the frequency that (1) physical restraint was used as (A) an emergency intervention, and (B) a nonemergency intervention, and (2) restricted housing or other types of administrative segregation or seclusion were used at such facility.” (C.G.S. 17a-22bb(g))

Department of Developmental Services. Individuals under the supervision of the Commissioner of DDS “...shall be protected from harm and receive humane and dignified treatment which is adequate for such person's needs and for the development of such person's full potential at all times, with full respect for such person's personal dignity and right to privacy consistent with such person's treatment plan as determined by the commissioner. No treatment plan or course of treatment for any person placed or treated under the direction of the commissioner shall include the use of an aversive device which has not been tested for safety and efficacy and approved by the federal Food and Drug Administration except for any treatment plan or course of treatment including the use of such devices which was initiated prior to October 1, 1993. No treatment plan or course of treatment prescribed for any person placed or treated under the direction of the commissioner shall include the use of aversive procedures except in accordance with procedures established by the Commissioner of Developmental Services. For purposes of this subsection, “aversive procedure” means the contingent use of an event which may be unpleasant, noxious or otherwise cause discomfort to alter the occurrence of a specific behavior or to protect an individual from injuring himself or herself or others and may include the use of physical isolation and mechanical and physical restraint. Nothing in this subsection shall prohibit persons who are not placed or treated under the direction of the Commissioner of Developmental Services from independently pursuing and obtaining any treatment plan or course of treatment as may otherwise be authorized by law. (C.G.S. Sec. 17a-238(b)).

Additionally, the DDS Commissioner is empowered to develop “...regulations, in accordance with the provisions of chapter 54, with respect to each facility or institution under the jurisdiction of the commissioner, with regard to the following: (1) Prohibiting the use of corporal punishment; (2) when and by whom therapies may be used; (3) which therapies may be used; and (4) when a person may be placed in restraint or seclusion or when force may be used upon a person.” (C.G.S. Sec. 17a-238(c)).

Specific rights include having a copy of any “...order prescribing the use of therapy, restraint or seclusion” in the individual’s permanent (clinical) record (C.G.S. Sec. 17a-238(d)) and “...to be free from unnecessary or excessive physical restraint” (C.G.S. Sec. 17a-238(e)(6)).

Department of Mental Health and Addiction Services. The only current statute addressing A/R/S and this state agency is that “No patient may be placed involuntarily in seclusion or a mechanical restraint unless necessary because there is imminent physical danger to the patient or others and a physician so orders. A written memorandum of such order, and the reasons therefor, shall be placed in the patient’s permanent clinical record within twenty-four hours.” (C.G.S. Sec. 17a-544(a))

Common Themes in CT Statutes. The common theme in laws governing the provision of education and human service is that nothing outright prohibits the use of A/R/S. Further, none of the statutes define “immediate” or “imminent danger,” and only define “emergencies” as circumstances in which these levels of danger are present, leaving the determination of what constitutes a genuine emergency requiring A/S/O intervention up to staff interpretations of agency regulations and policies, the extent to which said staff have been trained in alternatives to A/S/O, and the individual’s personal characteristics involving tolerance for disruption and personal reactivity to threat (c.f.

Sequeira & Halstead, 2004). According to Butler (2015), CT's statutes can only be considered "meaningful" to the extent they protect students with IEPs because other students (including those with disabilities who may have 504 Plans) are excluded.

4. **What Does the Research Say about Restraint, Seclusion Time Out, and Aversives and Punishment in General?**

Historical Background

It is critical to understand the history of inflicting punishment that has the potential to cause unintended harm to vulnerable individuals with disabilities in order to control their challenging behaviors.

Specifically, its original use was based in animal studies in which punishment was used to "modify" (i.e., control) the behaviors of animals such as pigeons (Appel & Peterson, 1965; Azrin, 1959; Brethower & Reynolds, G, 1962) rats (Karsh, 1863; Myer & Baenninger, 1966), and monkeys (Appel & Peterson, 1965; Glassman, Negrão, & Doty, 1969). Although animal research continues today as protested by the international organization PETA (People for the Ethical Treatment of Animals), the dates of the cited publications show clearly that this research controlling behavior through punishment occurred in a different era – one in which the deviance of people with disabilities was viewed as subhuman (Wolfensberger, 1972).

This different era also was one when harmful psychotropic medications were routinely in use in institutional settings such as Mansfield and Southbury Training Schools to control behavior. These medications resulted in serious side effects including Tardive Dyskinesia, a permanent change to the individual's neurology affecting their movement (Crane & Chase, 1968), and the need to administer these above what was considered to be a safe level (Eveloff, 1966). Punishments such as restraints and even shock to control behaviors were viewed as short-term and less harmful.

This different era also was when individuals who had disabilities and challenging behaviors routinely were sent out of their family homes and communities to institutions like Mansfield or Southbury and when regional centers were considered advancements because they provided institutional living on a smaller scale (Thorne, 1971). It was a logical leap, then, to ride the wave of behavioral tradition of B.F. Skinner (1953) and apply "operant conditioning" techniques to humans to get them out of the backwards and to behave in a manner more tolerant to staff (Wilson, Copas, & Ross, 1972).

As a result, there were numerous peer-reviewed publications in that different era which provided evidence that punishment was a viable alternative to, or offered a quicker fix when used in combination with, other strategies. Matson & Keyes (1988) found that contingent use of restraints combined with pharmacological restraint reduced aggression and self-injurious behavior in institutionalized adults far better than medication alone. Baumeister and Forehand (1972) found that verbal commands coupled with contingent electric shock were successful in reducing the stereotypical behavior of body rocking in institutionalized adults. Parents were trained by Rolider and Van Houten (1985) to use a "movement suppression time out" in addition to verbal reprimands when their children tantrumed, bit their arm, or poked another child. This technique involved "...guiding or forcing him into the corner...with his chin against the corner, both hands behind his back," If the child moved or said anything during this "movement suppression time out," the parents were taught to push their child further into the corner with force (Rolider & Van Houten, 1985). The same research team also recommended the use of mechanical restraints (e.g., boxing gloves, gauze wrapping) a/k/a "response prevention" to reduce thumb-sucking (Van Houten & Rolider, 1985). Forced toothbrushing and forced administration of Listerine (an "oral hygiene

punishment procedure”) was shown to be effective in managing such oral behaviors as rumination and finger-mouthing (Singh, Manning, & Angell, 1982) as was a sharp pinch (Minness, 1980). Water mist spray was found to be more effective than forced arm movement and facial screening in “treating” self-injury (Singh, Watson, & Winton, 1986) as was using “aromatic ammonia” (Tanner & Zeiler, 1975). Other research found that positive behavior supports were not as effective if an individual had not previously been exposed to punishers but increased dramatically in effectiveness when punishment was introduced (Pfiffner & O’Leary, 1987).

Some went so far as to claim that individuals had a right to aversive therapies if they yielded faster results than alternatives (Van Houten et al, 1990). Even today, many behaviors that some would argue are “hard-wired” are thought to be motivated by an individual’s desire to escape or avoid complying with socially acceptable expectations (Szabo, 2019).

History of the “Opposing View.” Coincidentally, the concept of community-based services as an alternative to institutional living was gaining momentum (c.f., Perske & Perske, 1980) although many parent organizations had already formed organizations in the 1950’s and 1960’s to keep their children home. Numerous lawsuits were being filed on behalf of institutionalized individuals because of their living conditions (Turnbull & Turnbull, 1975) and the human rights of people with disabilities was becoming a paramount consideration service delivery as a result of those lawsuits and through the efforts of national advocacy organizations such as TASH.org. TASH initially broke free of what was then called the “American Association on Mental Deficiency” because of a burgeoning body of research that even the individuals most challenged by disabilities could learn. It is important to note that TASH has gone through several name changes since its origin in 1970 to reflect people first language and much greater sensitivity to self-advocates. It is important to note that TASH continues to have an unwavering commitment to inclusion in all areas of life and social justice, including the use of only positive behavior supports.

Person-centered planning (c.f. (Mount & Zwernick, 1989) in addition to well-researched positive approaches to behavior (Reichle & Wacker, 1993) were being used more commonly. The articles touting punishment as an evidence-based practice were being printed at the same time as research in such positive practices as peer mentoring, use of systematic instructional strategies to teach functional skills, and focusing on antecedent conditions thought to “cause” maladaptive behaviors. This begs the question, How is a new ABA practitioner researching the origins of the field to know which “evidence based strategies” are acceptable to employ and which are not **because they are no longer necessary** when even the 2011 Position Statement on Restraint and Seclusion of The Association for Behavior Analysis International states that “restraint may be necessary on some rare occasions with meticulous clinical oversight and controls” and “Seclusion is sometimes necessary or needed” (Vollmer et al, 2011) in addition to other professionals who continue to advocate for their judicious use (LeBel, Nunno, Mohr, & O’Halloran, 2012)?

Research Grounded in Values.

As stated, the use of punishments in an effort to control the behavior of people with disabilities is well-documented and condoned (c.f. Lichstein & Schreibman, 1976). The “opposing view” just discussed, however, lays a values-based framework for revisiting this in the interests of human rights and dignity *regardless of disability*. As such, much research has clearly demonstrated that punishment in general is *not* effective. In a recent review of the literature, the abstract states the following:

“...punishment is linked with the same harms to children as is physical abuse... (This is) consistent across cultural, family, and neighborhood contexts...(P)arents should avoid physical punishment, psychologists should advise and advocate against it, and policymakers should develop means of educating the public about the harms of and alternatives to physical punishment.” (Gershoff, Goodman, Miller-Perrin, Holden, Jackson, & Kazdin, 2018).

Even parental spanking (defined as using an open hand to make forceful, sometimes repeated, contact with a child’s buttocks and generally considered to be the most benign form of physical punishment) has been conclusively shown to be ineffective in reducing non-compliant or aggressive behaviors as well as being tied to negative effects on the child being spanked (Gershoff, 2013). These include increases in mental health problems in childhood and adulthood, delinquent behavior in childhood and criminal behavior in adulthood, negative parent–child relationships, and increased risk that children will be physically abused.

Other forms of punishment are also ineffective, particularly when the benefit of the risk taken by an individual (e.g., to engage in delinquent behavior) is calculated to be greater than the punishment itself (Poon & Ho, 2016).

Adding Insult to Injury. One study reported that seventy percent of children restrained or be placed in seclusion time out in psychiatric facilities had histories of physical and/or sexual abuse prior to admission and are more to be re-traumatized by these “interventions” (Hammer, Springer, Beck, Menditto, & Coleman, 2011). Nunno, Holden, and Tollar, (2006) reviewed 45 restraint fatalities of youth aged six to eighteen years that occurred in 22 states in the decade from 1993-2003. Of these, 25 individuals’ deaths were attributed to asphyxia (suffocation) and 10 were attributed to cardiac arrhythmia that occurred during restraint. The cause of death or the remaining nine youth were listed as unknown (4), due to exertion (2), internal bleeding (1), blunt trauma (1), hyperthermia (1), and “sudden death.” Males were disproportionately represented (71%) and seven fatalities (7) also involved seclusion (Nunno, Holden, and Tollar, 2006). These same authors note that this is only a partial sample because many restraint-related deaths may go unreported.

Punishment doesn’t work. There are numerous studies that established early on that punishment does not work or, at best, is not as effective as alternatives to punishment (Donnellan, LaVigna, Negri-Shoultz, & Fassbender, 1988). For example:

- The individual must perceive the consequences as punishing. If not, consequences intended to decrease challenging behaviors may actually bring relief such as providing deep pressure or being removed from an environment or school requirements the student perceives to be aversive (Cataldo et al, 2007).
- Another issue identified by Torjman et al (2009) is the different responses to pain that some individuals, particularly those with autism, have as depicted in *Table 1*:

Type I: Paradoxical pain reactivity

Apparent pleasure reaction to a painful stimulus (such as smiling or laughing).

Type II: Absence of pain reactivity

Absence of any reactions described in class IV with absence of nociceptive reflexes (such as absence of hand withdrawal reflex when burning oneself or absence of arm withdrawal reflex from the needle during a blood drawing).

Type III: Hyporeactivity to pain

The individual with autism appears to withstand pain, but nociceptive reflexes to nociceptive stimuli are present. After noxious stimuli, the following possible abnormalities are observed: incomplete pain reactivity compared to class IV, abnormally delayed reaction time.

Type IV: Normal pain reactivity

After painful stimuli the following reactions are observed: cries, screams, moaning, grimaces, reflexes of nociceptive withdrawal, lack of movement, body orientation and glance towards the painful area (e.g., glance towards the venepuncture or sometimes away from it, also the individual with autism takes the observers hand to put it on the painful area of his/her body, a behavior often found in some non-verbal patients with autism), stopping an activity in progress, reaction when the injured area is touched, guarded body position when resting or in movement, spontaneous protection of the painful area. One of the important signs of pain reactivity for individuals without verbal language is the immobilisation of the painful area of the body.

Type V: Hyperreactivity to pain

Disproportionate cries and screams given the painful stimulus (with hypersensitive light touch).

From: Tordjman, S., Anderson, G. M., Botbol, M., Brailly-Tabard, S., Cohen, D., Perez-Doaz, F., Gaignic, R., Carlier, M., & Bronsard, G. (2009). Pain Reactivity and Plasma β -Endorphin in Children and Adolescents With Autistic Disorder. PLOS ONE, 4(8): e5289. doi: 10.1371/journal.pone.0005289

The danger, then, in using any type of physical contact related to administering a punitive consequences with students who may have idiosyncratic pain experiences is that even the slightest touch could be construed as extremely painful whereas harm can actually be inflicted without the student appearing to be in pain.

- Once consequences intending to punish (reduce) behaviors are administered and they do not work, there is a tendency for the person administering the punishment to increase the level of punishment (Goldstein, Davis, & Herman, 1975).
- Coercion also does not result in desired behavior change because the result is teaching students that it is acceptable to impose their will on others (Biesta, 2010).
- Punishment is not effective when it fails to get to address the reasons for misbehavior (Raffaele Mendez, 2003).

The problem with earlier research in which punishment appeared effective. The roots of the phrase, “spare the rod and spoil the child” can be found in the Old Testament (Proverbs 13:34). Other biblical phrases appear to support this strict approach to childrearing while others appear to recommend a more gentle approach (“Train up a child in the way he should go; even when he is old he will not depart from it.” Proverbs 22:6). Although some faith communities continue to take the corporal punishment advice literally, many world religions today interpret this in a gentler manner. This new outlook is due to changes in social conventions regarding corporal punishment and professional advice to parents (c.f. Benjamin Spock’s popular book, published in 1946, called “The Common Sense Book of Baby and Child Care”).

This shift, however, did not universally apply to individuals with disabilities who were, as stated previously, still viewed by society at large as “less than human” (c.f. Wolfensberger, 1972). In fact, in the professional literature on the treatment of people with disabilities, there was considerable controversy in the 1970’s as to whether punitive behavior analytic approaches including the use of electric shock to control “rocking behaviors” (c.f. Risley, 1968) were more effective than more humanistic approaches such as “gentle teaching” (Keith, 1979; McGee, Menolascino, Hobbs, & Menousek,

2009), although not all authors considered these approaches mutually exclusive (Emerson & McGill, 1989).

The average person not acquainted with “operant conditioning” would not be appreciative of what have been termed “Mild aversives (which) include a form of nonseclusionary timeout known as facial screening, the administration of certain irritating substances such as citric acid and aromatic ammonia, and the use of negative practice” (Alberto, 1983) for any behaviors they perform regardless of how challenging to the general public.

Research against the Use of Aversives, Restraints, and Seclusion Time Out

As early as the 1970’s, the seemingly benign procedure known as “Time Out from Positive Reinforcement” (TOPR) was broken into categories of “exclusionary time out” (removing a student from a reinforcing activity) versus “seclusionary time out” (isolating a student for the sole purposes of punishment). This was due to the plethora of legal and ethical issues that arose as a result of using TOPR in schools (Gast & Nelson, 1977). Unfortunately, the major consideration for use of seclusionary time out, as with other aversives, was the requirement of oversight by a Human Right Committee (Barton, Brulle, & Repp, 1983) which oftentimes had membership of individuals who were proponents of aversives, restraints, and seclusion time out. Despite these issues, Rozalski, Yell, and Boreson (2006) reported an increase in the use of TOPR of all forms during the 1990’s particularly with younger students for whom positive interpersonal relationships and supportive interactions with adults are of critical importance (NAEYC, 2012).

A comprehensive review of the literature determined that there is no evidence of therapeutic benefit when either restraints or seclusion is used for individuals with serious mental illnesses (Sailas & Fenton, 2000) and that continued use is based on faulty assumptions that there is benefit (Mohr & Anderson, 2001). Yet, in a study of a Connecticut school for behaviorally challenged youth published online in a peer-reviewed journal, French and Wojcicki (2017) found that “...in the 2012–2013 school year, 5% of the total enrollment (i.e., 10 students) accounted for 80% of the total frequency of physical restraint, and 7.5% of the total enrollment (i.e., 15 students) accounted for 80% of the total frequency of seclusion procedures.” Further, contrary to NAEYC standards, use was skewed toward younger children and, although the risk of injury in this superficial study, according to the authors, was low at only 0.002%, it could be argued that it was still seven incidents too many.

According to the Child Welfare League of America (2012-2016), “Restraint and seclusion are violent, high-risk procedures with the potential to harm youth and staff.” Such harm can be physiological or psychological.

Physiological harm. Respiratory functions can be compromised when prone restraint is coupled with weight force even in the absence of hypoxia or hypoventilation (Chan, Neuman, Clausen, Eisele, & Vilke, 2004). Reviews of the literature also cite the unknown variability in personal risk factors that could lead to the death of any particular individual to whom restraints are applied (Mohr, Petti, & Mohr, 2003). Other physiological problems include higher rates of pressure sores, acquired infections, falls, mortality, and incontinence as a result of restraint (Evans, Wood, & Lambert, 2003). A German study of some 27 thousand autopsies performed from 1997 to 2010 showed conclusively that 22 deaths were caused by restraint

Psychological harm. For individuals who have experienced trauma in which their movement was restricted, restraint can cause the trauma to be relived (c.f. Smith, 1995). Individuals subjected to physical restraint reported feeling upset, distressed and ignored prior to the incidents and isolated and ashamed afterwards (Bonner, Lowe,

Rawcliffe, & Wellman, 2002). Rarely has positive affect been reported post-restraint and this was only when the staff applying the restraints were perceived to be doing so in a nurturing, caring, and supportive manner rather than as being punitive (Chien, Chan, Lam, & Kam, 2005). Early studies suggested that restraint may actually serve as a reinforcer for negative behaviors and recommended that alternatives to restraint as a form of punishment be developed (Favell, McGimsey, & Jones, 1978). Restraint has also been shown to have lasting negative psychological impact on staff (Sequeira & Halstead, 2004).

Biologically-Based Behaviors. Biologically-based behaviors are behaviors that truly are out of an individual’s control. Consider these examples that you or anyone without a disability may experience:

- Your supervisor tells you to hold your breath for 10 minutes or you will get fired.
- The TSA official tells you an arrest is pending if you can’t get your asthma under control and get up off the floor
- A family member states you’re inconsiderate for hogging the bathroom and will lose television privileges because you are exhibiting symptoms commonly associated with the flu.

Without knowing the reasons for these behaviors (i.e., why you couldn’t hold your breath that long, control your asthma, or get out of the bathroom according to someone else’s agenda), someone might assume the you are being willfully noncompliant and intentionally doing whatever the person threatening the punishment does or doesn’t want them to do. No one would doubt that the consequences in these situations would be considered unfair.

Certainly people with disabilities may experience these same types of “impossible tasks” but there are also situations in which their behavior is truly out of their control because it is the result of either hardwiring in their brain or other physiological reasons that, because of their disability, they cannot describe to others. Given the disability labels rendering students eligible for IDEA services (20 USC §1401(3)(A)(i)), we might expect children with at least certain disabilities to exhibit biologically-based behaviors.

Table 2 provides examples of such challenging behaviors in students who have labels other than “serious emotional disturbance,” the eligibility designation in the IDEA (20 USC §1401(3)(A)(i))” one might expect would be most at risk of exposure to aversive procedures. Nonetheless, research on biologically based conditions associated with challenging behaviors within other eligibility designations begs the question why punitive consequences would be applied at all when positive approaches will suffice.

Table 2

Examples of Behaviors Directly Associated with Developmental Disability Labels¹ Leading to Eligibility for Special

Education²

Behavior	Eligibility Label	Sample Evidence
Pounding head or ears	Intellectual disabilities	Inability to verbalize a painful earache (May & Kennedy, 2010)
Externalizing behaviors (e.g., threatening, disrupting class activities, swearing)	Hearing impairments (including deafness),	Getting in trouble because relevant oral information was not heard (Mitchell & Quittner, 1996)
Higher risk for non-compliance, aggression, destruction, delinquency	Speech or language impairments (i.e., articulation, receptive or expressive not co-	Behaviors increase over time (Curtis, Frey, Watson, Hampton, & Roberts, 2018)

Behavior	Eligibility Label	Sample Evidence
Inappropriate peer interactions	occurring with other disabilities) Visual impairments (including blindness)	Inability to see and interpret social cues (Erwin & Hill, 1993)
See Traumatic Brain Injury Self-biting	Orthopedic impairments Autism	- Reduced sensitivity to pain due to elevated plasma β -endorphin levels (Tordjman et al, 2018)
Violent crime	Traumatic brain injury	Compromised brain systems involved in self-regulation, social connectivity, etc. (Williams et al, 2018)
Aggression, violence	Other health impairments, e.g., epilepsy	Brain dysfunction during post-ictal state involving frontal and temporal lobes (Ito, M., Okazaki, M., Takahashi, S., Muramatsu, R., Kato, M., & Onuma, T., 2007)
Fighting	Specific learning disabilities	Response to bullying (Cortiella & Horowitz, 2014)

¹ It is important to recognize that these are only single examples of behaviors that may be disability related.

² SOURCE: 20 USC §1403(3)(A)(i).

These examples raise a question about the recommendation for disciplinary actions as a result of a “manifestation determination” required under the IDEA (20 USCS §1415 (E)) if a student with a disability violates the school’s code of student contact (20 USCS §1415 (E)(i)) **unless one can be absolutely certain the behaviors did not have a biological basis**. The review of information required by the district, the parent, and other members of the student’s PPT must determine “(I) if the conduct in question was caused by, or had a direct and substantial relationship to, the child’s disability; or (II) if the conduct in question was the direct result of the local educational agency’s failure to implement the IEP (20 USCS §1415 (E)(1)(i)) and, if either of these sub-clauses is applicable, “...the conduct shall be determined to be a manifestation of the child’s disability” (20 USCS §1415 (E)(1)(ii)). Unlike the standards proposed by APBS, this does not require a thorough exploration of possible bio-physiological bases for certain challenging behaviors. Specifically, this IDEA provision unfortunately does not **require** other than a cursory examination of antecedent events such as bullying by other students, difficult student-teacher interactions due to personality conflicts or other factors, or other extenuating circumstances even though good functional behavioral assessments should consider multiple variables (APBS) because the focus is on the student.

Further, there is a high correlation between students with more severe developmental disabilities and psychiatric disorders (Emerson, Moss, & Kiernan, 1999). This is significant because the mental health field has banned the use of R/STO/A in both in- and out-patient psychiatric facilities (U.S. DOE, 2012). These are individuals who clearly have a biological basis for their challenging behaviors and should receive non-punitive therapeutic treatment up to and including a medication regimen coupled with positive interactive therapies on an individual or group basis.

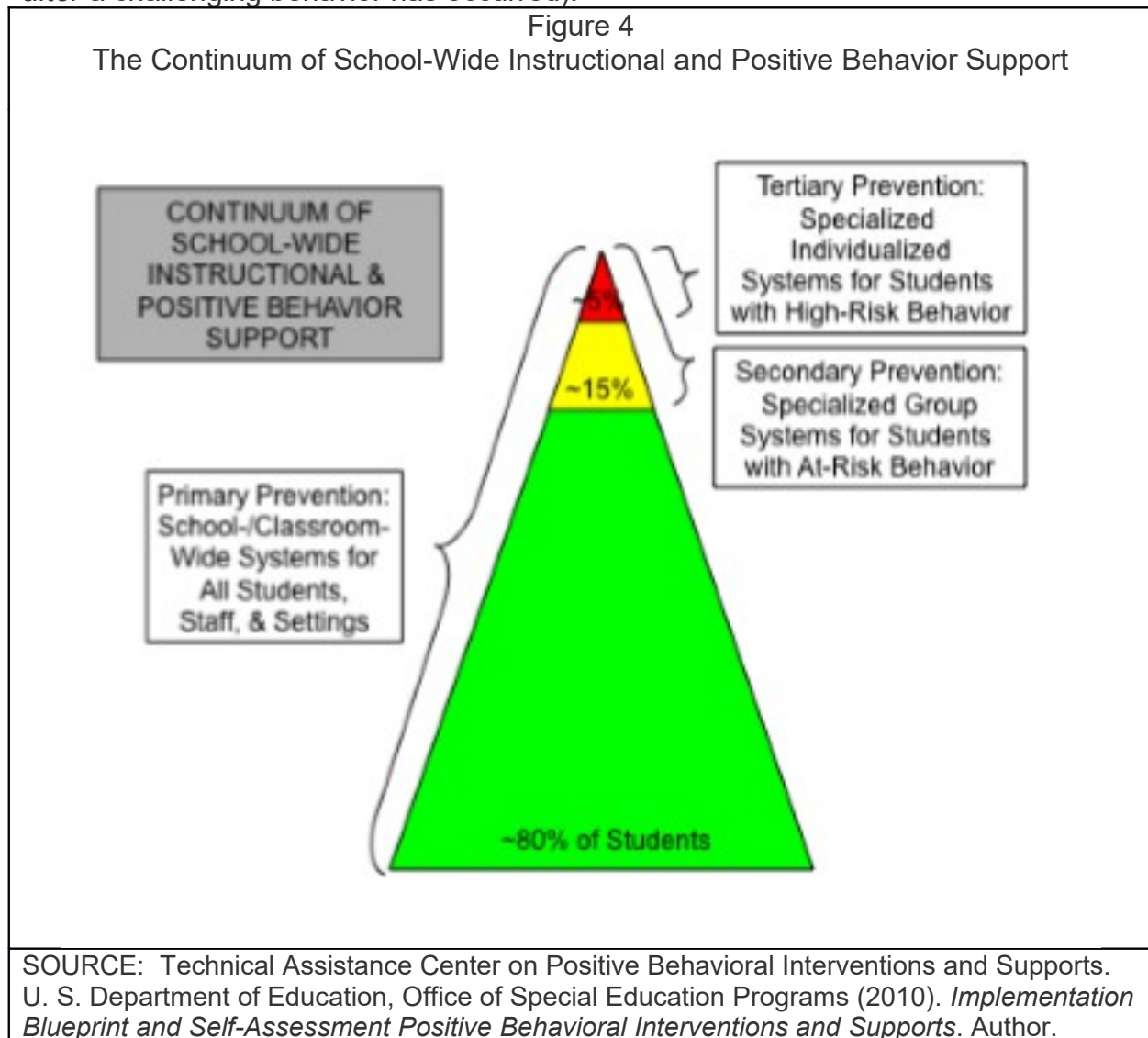
5. Recommendations for What to Do Instead

As a result of this history and research, the Association for Positive Behavior Supports (APBS) was founded in 2003 as a professional organization adhering strictly to the

principles and well-documented success of applied behavior analytic procedures that were not in any way aversive (Knoster, 2009). Another organization, APRAIS (the Alliance to Prevent Restraint, Aversive Interventions and Seclusion) "...was established in 2004 by leading education, research and advocacy organizations with a common goal: to eliminate the use of dangerous and dehumanizing practices as a means of managing challenging behavior. Led by TASH, APRAIS seeks to end of use of unnecessary and dangerous interventions in schools, treatment programs and residential facilities (TASH, 2019)."

APBS and Connecticut

One of the founding members of APBS was UConn Professor George Sugai who, with Rob Horner and other well-published applied behavior analysts, received a federal grant from the Office of Special Education Programs to establish a three-tiered system of PBS that came to be known as School-Wide Positive Behavior Supports. This system is now widely used and described in great detail on the website of the Technical Assistance Center on PBIS (q.v. <https://www.pbis.org/>). It is not the purpose of this paper to go into great detail about this project but a brief summary is that the approach consists of three levels depicted in *Figure 4*. Note that each level speaks to *prevention* (i.e., actions *before* challenging behaviors occur) rather than *interventions* (i.e., that imply action *after* a challenging behavior has occurred).



Retrieved from:

https://www.pbis.org/common/cms/files/pbisresources/SWPBS_ImplementationBlueprint_vSep_23_2010.pdf

The first level, which applies to almost all students in the school environment, is often referred to as “Tier I – Primary Prevention” and involves a whole-school commitment to establishing and reinforcing a set of prosocial rules. Many studies, taken from the pbis.org website and listed in *Appendix A*, have clearly documented this approach in reducing, e.g., occurrence of behavioral incidents that are at least mildly disruptive to the school process. The second level, which applies to students who are not fully responsive to Tier 1 prevention strategies, is called “Tier 2 – Secondary Prevention.” According to the pbis.org website, “Tier 2 support is designed to provide intensive or targeted interventions to support students who are not responding to Tier 1 Support efforts. Interventions within Tier 2 are more intensive since a smaller number of students requiring services from within the yellow part of the triangle are at risk for engaging in more serious problem behavior and need a little more support.” A list of articles documenting the evidence base for Tier 2 interventions, also taken from the pbis.org website, appears in *Appendix B*.

The third level – i.e., “Tier 3 – Tertiary Preventions” – applies only to a small population of students who are not responsive to Tier 1 or Tier 2 interventions. Although Tier 3 is not actually addressed in SW-PBIS (personal communication, George Sugai, April 22, 2013):

“The research supporting the effectiveness of functional behavioral assessment, the design of individualized behavioral interventions, and the active use of data in the implementation of behavior support is perhaps the most robust of the databases within SWPBS. The majority of this research has employed single-case designs to examine the effects of specific interventions, but increasingly studies are linking behavioral and academic interventions to reduction in problem behavior.” <https://www.pbis.org/research/tier3supports>

A list of articles from the website providing the evidence base for these interventions appears in *Appendix C*.

Although the model in *Figure 4* refers to organizational and instructional supports specifically in schools, the same positive, preventative approach has been applied across settings providing services to, for example, youth experiencing mental health challenges (Weisz, Sandler, Durlak, & Anton, 2005).

Interestingly, as of 2018, Connecticut has yet to become actively affiliated with APBS. “APBS published its initial Standards for Practice (Individual Level) in 2008. Further, this publication served as the foundation of Individual Positive Behavior Support: A Standards based Guide to Practices in School and Community Settings (Brown, Anderson, & De Pry, 2014). This set of standards provides guidance to the field in terms of the necessary components/elements of Tertiary Level Positive Behavior Support to support individuals who have a history of problem behavior (children through adult populations).” Source: (APBS, 2018). What this means is that CT has not adopted in any way, either as a state or through a university or other organization within the state, the APBS Standards of Practice which specifically prohibit and require that:

“C. Practitioners applying PBS with individuals include at least 11 key elements in the development of PBS supports

1. Collaborative team-based decision-making
2. Person centered decision-making

3. Self-determination
4. Functional assessment of behavior and functionally derived interventions
5. Identification of outcomes that enhance quality of life and are valued by the individual, their families and the community
6. Strategies that are acceptable in inclusive community settings
7. Strategies that teach useful and valued skills
8. Strategies that are evidence based, and socially and empirically valid to achieve desired outcomes that are at least as effective and efficient as the problem behavior
9. Techniques that do not cause pain or humiliation or deprive the individual of basic needs
10. Constructive and respectful multicomponent intervention plans that emphasize antecedent interventions, instruction in prosocial behaviors, and environmental modification

11. Ongoing measurement of impact (APBS, 2013).

Adhering to the rigorous guidelines for PBS would further reduce any potential use of aversive procedures for individuals with the exception of extinction (ignoring), differential reinforcement, response cost (i.e., removing a desired object), and limited, supervised timeout (what this author prefers to call “time away”) that most certainly does NOT include seclusion time out as it has been defined (APBS, 2013). For example, it is highly unlikely that any individual would determine for themselves that they should be subject to aversive procedures when other procedures will suffice (key element 3), that application of the aversives described previously would be acceptable in inclusive community settings (Key element 6), or, by definition, would not cause pain, humiliation or deprive the individual of basic needs (Key element 9).

As French and Wojcicki (2017) described, all CT schools could have policies in place that mandate at least the more severe types of aversives – i.e., that restraint or seclusion:

“...only be implemented as emergency interventions to prevent immediate or imminent injury to the student or to others. Examples of student behavior that (meets) this criterion include significant physical aggression toward a peer or a staff member (i.e., hitting, kicking, biting) and severe self-injurious behaviors (i.e., head banging, biting, a young child running into the street). The school’s behavior management protocol also maintained that physically assaultive or otherwise dangerous behaviors responsive to less restrictive interventions (e.g., verbal de-escalation, physical prompts, and considerable attempts at redirection or encouragement toward safe behavioral alternatives) *were not to result in the use of restraint or seclusion procedures*. In other words, even in the event that a child aggressively and repeatedly strikes his or her teacher, restraint or seclusion was not to be implemented if the child was able to regain control in response to less restrictive interventions. Moreover, restraint and seclusion procedures were only to be used for the period of time necessary for the student to regain physical safety.”

Coupled with this policy was intensive staff training and supervision to assure that the policy was carried out with fidelity and that only safe intervention techniques, in which staff also were well-trained, were to be used if at all. What was not clear from the study was the extent to which those students who were subjected to A/R/S were communicating something else by their behaviors that was not being addressed with permitted interventions.

Building Relationships.

NAEYC’s recommendations for young children applies to ALL children, particularly those who have already experienced abuse and/or neglect (Ezzell, Swenson, & Brondino, 2000; Haskett,

Nears, Ward, & McPherson, 2006.) “Relationship is not just ‘nice to have.’ It is a critical component of any behavioral intervention strategy. It is through relationship that we get to know someone well enough to read their cues and know what to do (Rammler & Carbone, 2009). Indeed, positive associations between positive affective relationships between teachers and students and enhanced student achievement as compared to the adverse effect on student achievement when affective relationships with teachers are negative have been well-established (Roorda, Koomen, Spilt, & Oort, 2011). There are numerous strategies described in the literature about ways to build relationship.

Teaching to student learning styles. One preventative measure that is critical for all teachers to embrace is to teach to individual student learning styles. There are many approaches to learning styles (c.f. Cassidy, 2004) and meta-analyses have shown some to be quite robust in improving student learning (c.f. Dunn, Griggs, Olson, Beasley, & Gorman, 1995; Smith & Renzulli, 1984). Although learning style models have had their share of criticism for being, e.g., difficult to quantify, not stable over time, affected by experience, or specific to a particular learning task rather than being generalizable traits across all learning (Cassidy, 2004). Thus, the best solution is for teachers to employ evidence-based strategies of *differentiated instruction* (Jones, Yssel, & Grant, 2012; Kulik & Kulik, 1992; Subban, 2006; Tomlinson, 2001) to reach and teach ALL students including those with social-emotional challenges who are most likely to be exposed to R/STO/A (Borders, Jones Bock, & Michalak, 2012; Hoover, & Patton, 2004; Lawrence-Brown, 2004; Rock, Gregg, Ellis, & Gable, 2008). Relationships also apply to peers as classroom and school communities are built using such strategies as “You can’t say you can’t play” in kindergarten (Harrist & Bradley, 2003; Paley, 2009) to intentionally building cooperative, inclusive classroom communities (Sapon-Shevin, 2010; Sergiovanni, 2003),

Avoiding “miscalls.” A “miscall” is when you misinterpret or fail to understand the reasons behind a behavior and you attribute it to something else that just makes the situation worse (Seeman, 1984). When giving a workshop, for example, I may see a participant turn to a neighbor and whisper. The whispered message may be appropriate (e.g., “Your fly is down” or “Are you okay?”) but, if I yell “HEY! I’m talking. Do we talk when the presenter is talking? That’s rude!” I would have seen the whispering, called the whisperer on it, but called it wrong. There are many common miscalls that take place in classrooms daily because, despite their best efforts, teachers do not have multiple eyes to see all around the classroom simultaneously. Some common miscalls are “the under the microscope phenomenon” where the only student who “gets in trouble” is the one with the “bad reputation” and over-reacting to a behavior as a problem when it actually is age-appropriate (Rammler & Carbone, 2009).

Being a Communication Detective

The “communicative intent of behavior” –i.e., that behavior does not occur in a vacuum but rather is a means of communicating to others in the absence of the necessary communication skills – has been well documented (Prizant & Wetherby, 1987). Possible communicative functions include how the individual feels physically and psychologically; whether a task is too repetitive, boring or too difficult; post-traumatic stress responses; a commentary about an environment that is noxious, uncomfortable, or unstimulating; an attempt at pro-social behavior; and a myriad of other “commentary” that an individual, particularly a non-verbal one or someone with a limited vocabulary, can express in words (Rammler & Carbone, 2009).

The Criterion of the Least Dangerous Assumption. The concept of the Criterion of the Least Dangerous Assumption states that “in the absence of conclusive data educational decisions ought to be based on assumptions which, if incorrect, will have the least dangerous effect on the likelihood that students will be able to function independently as adults (Donnellan, 1984).” The least dangerous assumption with respect to challenging behaviors is that they were not a function of malice or ill-intent but rather served a specific communicative function for the individual. Assuming that children will be good “if they could” is a fundamental premise of a treatment approach called “Collaborative Problem-Solving” (Greene, 1999) that has been shown to have a significant impact on the use of aversive procedures as young people are taught appropriate means of handling their explosivity.

Avoiding the parsimonious theory of escape and avoidance trap. Early on in the field of applied behavior analysis, the concept of challenging behavior being sustained by means of “negative reinforcement” was discussed (c.f. Carr, 1985). Negative reinforcement is not the same as punishment. Whereas punishment is an event that, when ADDED following a behavioral incident, DECREASES the behavior, negative reinforcement is a consequence that, when REMOVED following a behavioral incident, INCREASES the behavior. Compare this to *positive reinforcement* that, when ADDED following a behavior, INCREASES the behavior. The idea, then, is that behavior is sustained when an individual wished to avoid doing a particular task or participating in a specified activity, the challenging behavior removes the opportunity to engage in that task or activity. This removal then reinforces the challenging behavior.

As a result of this possible motivating factor in, e.g., aggressive or self-injurious behaviors, many behavioral therapists ignored the other possible motivating factors. That is, these behaviors could be sustained by positive consequences (social attention, for example), to self-stimulate for reasons not specified, or because of some physiological challenges (Carr, 1977, 1985).

Although the parsimonious theory that negative behavior can be reduced in understanding and treatment to only two variables has gained popularity among many behavior therapists, there is also justification, as just noted (Carr, 1977; 1985) to look for other factors that resulted in the behavior. NASMHPD identified the questions appearing in *Figure 5* as necessary to ask and answer in detail as part of a “formal rigorous event analysis” in order to prevent any recurrence of R/S use.

Figure 5

Required Reporting of R/S Use

- A. A description of the event (what happened)
- B. What was the result (seclusion, restraint, involuntary medication, any injuries to staff or patients)
- C. Who was involved in events leading up to the seclusion, restraint or involuntary procedure
- D. What were the antecedents (patient history, past events, behavior immediately prior to the event)
- E. Was there any warning or change in behavior prior to the event and what did staff do?
- F. Did we know that this was a high risk for violence person? If so, what had been done to prevent this event?
- G. What was the source of the conflict, if any?
- H. What did staff do?
- I. When the escalating behavior was noted, were other interventions tried, and if so, what and what was the response?
- J. Did the person have a relationship with anyone on staff at this time of the event and did that

person try to intervene?

K. Was the person offered alternatives and what was the response?

L. Had the person developed a safety plan and was that used?

M. What staff were directly involved and are they ok?

N. Is the person safe and where are they now?

O. What have staff done to prevent another occurrence?

P. What is the person saying at this point, if anything?

Q. Were the event “observers” debriefed and how are they?

R. Were the staff involved debriefed and how are they?

S. Is there anything, right now, that you can add regarding how this event could have been avoided?

T. Can you attend or “call in” for the formal event debriefing and, if not, how can we get your information to the team members who will debrief this event.

U. Is there anything that can be done now to prevent this from happening again?

Source: National Association of State Mental Health Program Directors (2008). Six Core Strategies for Reducing Seclusion and Restraint Use. Alexandria, VA: NASMHPD.

An in-depth analysis of: 1) triggers, 2) antecedent behaviors, 3) alternative behaviors, 4) least restrictive or alternative interventions attempted, 5) de-escalation preferences or safety planning measures identified and 6) treatment plan strategies is also required as are answers to the questions appearing in *Appendix D* of an eleven step process for debriefing strategies following any instance of use of R/STO in any setting (NASMHPD, 2008). One study found that simply conducting Risk Assessments had no impact on the use of A/R/S (Gaynes et al, 2016) suggesting that this comprehensive approach is indeed necessary.

Between 1980 and 1995, Cedarhurst, a Yale-run school for students with social-emotional challenges, documented weekly restraints but, after implementing Schoolwide Positive Behavior Supports (SW-PBIS with fidelity), reported no use of restraints at all from 2009-2012, the three years after which SW-PBIS was fully implemented (Cedarhurst, n.d.). Additionally, implementation of just Tier 1 of SW-PBIS has been shown to increase positive behaviors recognized by faculty and staff, decrease office referrals for disciplinary reasons (often the first step in a series of increasingly harsher disciplinary measures), and staff’s subjective views of improved behaviors among all students (Farkas, Simonsen, Migdole, Donovan, Clemens, & Cicchese, 2012).

Common sense. In the tenth case cited by the U.S. General Accounting Office (2009), the student reportedly attempted to stab a counselor but this was after the counselor went into the student’s room to address a fight he had just had with another student. Neuroendocrinologist Richard Sapolsky (1994) suggests that stress hormones resulting

in a “fight or flight” response can take minutes to hours to abate. One wonders if the counselor had just waited longer if this event (in which he was not actually stabbed) could have been prevented and the student would still be alive.

Meaningful Consequences.

Does all this mean students should “get away with whatever they want to do?” Absolutely not. As Yang (2009) pointed out:

“Punishment is retribution for an offense, an exclusionary act by which students are removed from the opportunity to learn; it is harm inflicted by an external agent as a mechanism through which outside regulation becomes internalized subjectivity. Too often, this is the rubric from which we speak of classroom management and school policies that include detentions, suspensions, and expulsions. By contrast, discipline is an act of rigorous physical or mental training, a practice of will...”

Four specific evidence-based strategies have been shown to result in actual learning by students of such alternatives to challenging behaviors as coping or compensatory strategies regardless of the functional intent of those behaviors. By definition, because they **follow** the behavior, they are “consequences.”

Teachable Moments. Another issue concerning punishment is that the individual has to perceive the consequences as punishing (Cataldo et al, 2007). For a student who misbehaves in loud, confusing environments because they are overtired or overstimulated, the typical consequence is to remove the child from that environment. The child does not learn coping strategies for loud, confusing environments but rather that misbehavior will bring relief. Instead, such consequences (e.g., missing the assembly, not eating in the cafeteria, being secluded in a classroom with an enclosed time out space) may actually be *reinforcing* to the individual because *reinforcement*, by definition, means that the probability of behavior will recur *increases*. A preferable strategy would be to systematically desensitize such students to the change in routine, less familiar environments, and/or noise levels using positive reinforcement for increasing tolerance of these naturally occurring situations (Koegel, Openden, & Koegel, 2004) and teach coping strategies (Baron, Groden, Lipsitt, & Groden, 2006). Lebel, Huckshorn, & Caldwell (2010), in a revealing article titled “Restraint use in residential programs: Why are best practices ignored?” admit that the culture of using restraints to address violent behaviors in residential “treatment” centers are difficult to change despite overwhelming evidence of the positive effects of alternative strategies. For culture change to occur, these authors state:

“Efforts to reduce restraint/seclusion are most successful when policies, procedures, and practices are based on prevention, trauma informed care, family-driven and youth-guided care, and building resiliency... Staff training should address the experiences of youth placed in restraint/seclusion, common myths, information on the impact of trauma, trauma-informed care, and crisis prevention strategies... Leadership must provide guidance for staff to suspend institutional rules, when necessary, to avoid or resolve conflicts when addressing individual needs. Examples of possible rule suspension scenarios include attendance at activities, wake and sleep times, using points and level systems, and other practices that do not adequately take into account individual needs, trauma history, and emotional, behavioral, or cognitive challenges. Staff should be empowered to make decisions— in the moment—to avoid using restraint and seclusion... Specifically, assessing for trauma, medical risk (e.g., obesity, cardiac anomalies, medication, past trauma histories), and risk for violence (e.g.,

previous restraint and seclusion history) are key. In addition, each child should have a crisis/safety plan, developed with the child and family, to help the youth learn how to recognize what triggers their distress, how they experience the upset, and what interventions help them calm down. Learning how to self-soothe is the essential outcome of these interventions. Changing the physical environment to make it more attractive, normalized, and comfortable (i.e., comfort and sensory rooms) is another important prevention tool, as well as implementing a range of sensory modulation approaches and expanding meaningful, engaging activities.” (Lebel, Huckshorn, & Caldwell, 2010)

It also makes sense to assure that our most vulnerable citizens are provided with enjoyable and productive activities rather than being forced to comply with demands that may have no bearing on the overall quality of their lives. We know from the expansive literature of the benefits of employment, for example, that individuals who are employed are less likely to engage in challenging behaviors even if they have substantial histories of doing so in unmotivating environments. Further constructive activity can range from exercise programs to maintain good health (Elliot, Dobbin, Rose, & Soper, 1994) through engagement in activities that promote enjoyment and happiness for each individual (Reid & Green, 2006).

Trauma-informed interventions. The National Traumatic Stress Network was funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services and jointly coordinated by UCLA and Duke University. A quick scan of the website (<https://www.nctsn.org/>) reveals multiple strategies, beyond the scope of this paper, which include individual and family Cognitive Behavioral Therapy, the triage-based Trauma Assessment Pathway, nurturing care for “attachment and biobehavioral catch-up,” Psychological First Aid, and Skills for Psychological Recovery. These are, however, no results yielded for the search terms “punishment” or “consequences.”

In fact, there are 10 principles of trauma-informed care (in contrast to “trauma-denied” treatment in which the effects of trauma are ignored) that have been proffered in a SMHSA-funded project. These are:

1. The impact of violence and victimization on development and coping strategies must be recognized.
2. The primary goal is recovery (not management of symptoms).
3. Services employ an “empowerment model” of the individual (as opposed to power *over* the individual).
4. Facilitating choices and the individual’s control over recovery is essential.
5. Services are based on relational collaboration.
6. The atmosphere in which trauma-informed services are provided must be respectful of a survivor’s need for safety, respect, and acceptance
7. The emphasis is on the survivor’s strengths, highlighting adaptations over symptoms and resilience over pathology.
8. Another goal is to minimize the possibilities of retraumatization.
9. Each individual has a unique context of life experiences and cultural background to requiring cultural competence.
10. Consumer input and involvement must be solicited in designing and evaluating services. (Elliott, Bjelajac, Fallot, Markoff, & Glover Reed, 2005).

From the previous discussions of punishment, it is clear that none of these criteria are met.

The power of natural consequences. For many years, research has documented the power of “natural consequences” in helping children learn what *not* to do (c.f.,

Wasicsko, & Ross, 1994). Examples are numerous (e.g., missing the bus because of a tantrum at breakfast time, losing a friend because you were mean to them, getting a stomach-ache from eating too much cherry pie, not having use of electronic equipment because you broke it which occur without any action on the part of an adult) or when a child is startled by an adult reaction to dangerous behavior such as wandering into the street. For natural consequences to be effective, they must be coupled with “positive discipline”— i.e., clear expectations of success, a sense of belonging/community, positive relationships between authority figures and students as seen by the students, development of trust, and teachable moments for what are considered “mistakes” rather than transgressions (Strahan, Cope, Hundley, & Faircloth, 2005). In other words, the focus after the behavior is a gentle debriefing of what could have been done instead and how the student can get help to avoid future incidents.

Meaningful restitution. Finally, we know that one of the most effective *consequences* for behavior if antecedent controls don’t work is an older intervention: i.e., restitution (Foxy & Azrin, 1972) known in other fields as “restorative justice (Fronius, Persson, Guckenburg, Hurley, & Petrosino, 2016).” Essentially, the relationships broken as a result of the challenging behaviors are restored and this, in and of itself, serves as a deterrent to challenging behaviors that could otherwise lead to the use of A/R/S. Examples include doing something nice for someone whose feelings were hurt, giving extra help or performing community service that is directly related to the behavior (e.g., working in a soup kitchen if food was thrown during mealtime), or earning money to help defray the cost of replacing a broken item. Oftentimes, a simple but sincere apology will suffice. As with natural consequences or positive discipline, trauma-informed interventions, and teachable moments, the time to offer these alternatives to repair relationships is after calm has been restored and the student is receptive to gentle suggestions. All of these approaches also presume there are no bad children, only challenging behaviors that good children would control themselves if they could (Greene, 1999).

Conclusion

Perhaps the most compelling reasons for more federal and state statutory changes has been summed up by Rob Horner and George Sugai (2013) as follows:

“Seclusion and restraint procedures are inappropriately selected and implemented as “treatment” or “behavioral intervention,” rather than as a safety procedure.

“Seclusion and restraint are inappropriately used for behaviors that do not place the student or others at risk of harm or injury (e.g., noncompliance, threats, disruption).

1. Students, peers, and/or staff may be physically hurt or injured during attempts to conduct seclusion and restraint procedures.
2. Risk of injury and harm is increased because seclusion and restraint are implemented by staff who are not adequately trained.
3. Use of seclusion and restraint may inadvertently result in reinforcement or strengthening of the problem behavior.
4. Seclusion and restraint are implemented independent of comprehensive, function-based behavioral intervention plans.

As Horner and Sugai (2009) also state in their recommendations for effective policy, “The majority of problem behaviors that are used to justify seclusion and restraint could be prevented with early identification and intensive early intervention. The need for seclusion and restraint procedures is in part a result of insufficient investment in prevention efforts.”

Although even these well-respected “gurus” of PBS also make room for the emergency application of restrictive procedures of restraint and a supervised and safe seclusion time out, one

has to question given the current values towards people with disabilities and the enormous base of evidence concerning approaches that are positive whether there will be a time when such strategies are not used at all. As said before, even one death or one injury resulting from these procedures is one death or injury too many. And, when this is taken in light of the other physical and psychological effects of such treatment, why a wholesale effort to eliminate all aversives altogether, and replace these with positive relational strategies that are evidence-based, could not be achieved.

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Appendix A

Tier 1 Schoolwide Positive Behavior Interventions and Supports

SOURCE: <https://www.pbis.org/research/tier1supports>

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Appendix B

Tier 2 Schoolwide Positive Behavior Interventions and Supports

SOURCE: <https://www.pbis.org/research/tier2supports>

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Appendix C

Tier 3 Schoolwide Positive Behavior Interventions and Supports

SOURCE: <https://www.pbis.org/research/tier3supports>

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Appendix D
Eleven Step Process of the National Association of State Mental Health Program
Directors' Recommendations for Debriefing Strategies Following Any Instance of
Use of R/S
in Any Setting

Step 1: Has a treatment environment been created where conflict is minimized (or not)?

This intervention opportunity asks staff to consider whether the agency has done everything possible to create a treatment setting that prevents conflict and aggression. Potential preventative interventions include the use of person-first language; adopting a trauma informed, recovery focused philosophy of care; comparing actual operational practice, policy and procedures against recovery and trauma informed values; assuring the staff have the knowledge, skill and ability in building therapeutic relationships immediately on admission; making the treatment environment welcoming and non-stressful; using prevention tools such as admission based trauma assessments, risk assessments, safety planning, comfort and sensory rooms and avoiding overt and covert coercion.

Questions to think about or explore:

- 1) Was the environment calm and welcoming?
- 2) Was the environment personalized and normalizing or institutional?
- 3) Was the milieu calm and mostly quiet?
- 4) Had any staff developed a relationship with the individual?
- 5) Were there signs about rules, warnings or other indications that might cause a feeling of oppression?
- 6) Did the individual witness a S/R or other upsetting event?
- 7) What were the trigger(s) to the aggressive or dangerous behavior?
- 8) Did we know the individual well enough to know their personal triggers?
- 9) Was the individual a trauma survivor and if so, did something in the environment create a traumatic re-enaction?
- 10) What set the individual off?
- 11) Did anyone on shift talk to the individual or "check in" before the event?
- 12) Was the individual's behavior a change during the shift or earlier?
- 13) Did the individual want something before the event occurred?

Step 2: Could the trigger for conflict (disease, personal, environmental) have been avoided (or not)?

This intervention opportunity addresses the adequacy of the screening and admission process and the skilled gathering of information, specifically risk factors for conflict and violence that can alert staff to the needs for immediate, preventative interventions. For instance, are staff aware that the individual has not been taking his or her medications for some time and has this issue been addressed immediately on admission? Is information gathered in the pre-screening or admission process relating to the individuals past history of aggression or violence on inpatient units and past experiences of being in restraint or seclusion? Do staff know or try and discover, during admission, each person's individual triggers for conflict, anxiety, fear, discomfort, "fight, flight, freeze" and document these so that they can be communicated? Are advance directives/safety plans developed and used? Does the facility understand the importance of minimizing a rule-based culture of care; minimizing wait times, avoiding shaming or humiliation (intentional and unintentional) of people in daily operations and other institutional issues?

Questions to ask?

- 1) Did the individual participate in the admission process and treatment planning process?
- 2) Was a trauma assessment done?
- 3) Was a safety plan done?
- 4) Did we know if the person had ever been in S/R before?
- 5) Did the individual receive a phone call or a visit (or lack thereof) that might have caused escalation?
- 6) Was the individual worried about anything?
- 7) Did the individual have to wait an inordinate time for something he or she wanted?
- 8) Did the individual indicate they needed help, attention or assistance beforehand?
- 9) Was the individual ignored, treated rudely, shamed, humiliated or consequence for some behavior?
- 10) Was the individual taking medication and if so, did they have a therapeutic level? Were they experiencing side effects?
- 11) Was the individual experiencing signs and symptom of mental illness?
- 12) Was the individual oriented to the unit and the rules?
- 13) Is this first admission?

Step 3: Did staff notice and respond to events timely (or not)?

This intervention opportunity addresses the staff culture and knowledge base regarding immediate and direct person-to-person responses to changes in individual adult or child behaviors in the milieu. In many facilities staff do not respond immediately due to lack of knowledge regarding types of behavioral escalation that can include both obvious agitation as well as isolative behaviors. In other facilities, staff sometimes have been taught to ignore disruptive or different behavioral changes in the belief that this is attention-seeking behavior and that ignoring it may make it “go away.” However, in recovery-oriented facilities, behavioral changes are seen as “attempts at communication” albeit perhaps not clear or direct, that require an immediate and respectful response. Unit staff need to be trained to observe for, detect and respond to changes in the individual behavior or the milieu in general as part of their job and as an important skill in refining the “therapeutic use of self” that is part of being a mental health professional or paraprofessional.

Questions to ask?

- 1) Who responded and when?
- 2) Was there any warning that the individual was upset?
- 3) What were the first signs and who noted them?
- 4) If no one noticed, why?
- 5) Should the person have been on precautions?

Step 4: Did staff choose an effective intervention (or not)?

This response addresses the knowledge, skills, abilities and personal empowerment of agency staff in identifying an appropriate and least restrictive approach to escalating behavior and then implementing that approach directly and immediately. The ability to formulate an immediate response to an escalating behavioral or emotional problem is not innate and usually requires training and role modeling by clinical supervisors. In addition, the agency culture needs to empower staff to be creative and to, at times, break unit rules to avoid the need for S/R when it is safe to do so. Examples of the latter might include allowing someone to leave group or take personal time in their bedroom during group hours; taking a smoke break to talk to a staff member between smoke break hours; having a snack between meals, being allowed to make a phone call or have a visitor. Unit rules can be interpreted by staff as sacrosanct and

this will discourage the use of least restrictive measures and lead to unnecessary S/R. In addition, fears by staff that “rule breaking will lead to chaos” have not generally been a reality. Individuals who may seem to learn how to get staff to bend rules by acting out will require evaluation by clinical treatment team staff. In general, in our rule based environments, it is fairly easy to label people as manipulative who seek to bend rules but it is important to remember that these rules are institutional in nature and not ones that we apply to ourselves or the client in their natural community.

Staff’s ability to be creative and to take the time to try and get to know the individual and his or her needs in crisis is immeasurably helpful and needs to be a part of the expectations for staff knowledge, skills and abilities in the agency job descriptions and performance evaluation process.

Questions to ask?

- 1) What intervention was tried first and by whom?
- 2) Why was that technique chosen?
- 3) Did anything get in the way of the intervention?
- 4) Did anyone get in the way of the intervention?
- 5) Was the intervention delayed for any reason?
- 6) How did the person respond to it?
- 7) What was the individual’s emotional state at the time?
- 8) What was the staff’s emotional state at the time?
- 9) What else could have been tried but was not?
- 10) Why not?

Step 5: If the Intervention was unsuccessful was another chosen (or not)?

Same as above. Staff need to continue to try alternatives until an intervention works or behavior escalates to the danger level. In the latter situation this is known as “treatment failure” not because the staff person(s) personally failed in their attempt but because the agency did not know enough about the person or had not yet had an opportunity to build a relationship where an intervention could be chosen that was effective.

Questions to ask?

- 1) Same as above

Step 6: Did staff order S/R only in response to imminent danger (or not)?

This step addresses the premature use of S/R for behavior that is only agitated, disruptive or, at times, destructive but where the individual still has control and can be engaged. This step also addresses S/R patterns of use where individuals are restrained or secluded “every time they hit someone or throw something but then stop” or other usually unwritten but common patterned practices. Patterned staff responses for behavioral “categories” such as throwing something, hitting inanimate objects, refusing to get up off the floor, constant pacing, kicking or hitting in one time only “strikes” need to be discussed and re-framed. At times these patterns are due to staff not understanding common signs and symptoms of mental illness or trauma response histories, leading to individual being blamed for intentionally “acting out” requiring consequences. However, care must be taken to assure that staff need to be free to respond if they feel they are in danger and that unnecessarily restrictive responses will be addressed through training and supervision first.

Questions to ask?

- 1) What was the exact behavior that warranted S/R?

- 2) Did it meet the threshold of imminent danger (what would have happened if S/R was not used)?
- 3) Who made the decision and why?
- 4) Did the staff member making the decision have good rationale based on training and experience and knowledge of the individual?

Step 7: Was S/R is applied safely (or not)?

For every instance of the use of S/R an objective senior clinical staff needs to assess whether staff followed the agencies policy and procedure for application. In addition, for some agencies, policies may need to be revisited for safety in terms of medical/physical risk factors and the use of prone restraint.

Questions to ask?

- 1) How was S/R applied and did it follow policy and safety precautions?
- 2) Were enough staff available to assist?
- 3) Did a professional nurse provide oversight of the event?

Step 8: Was the individual monitored safely (or not)?

One to one, face to face monitoring of individuals in seclusion or restraint is the safest way to monitor use. This does not include the use of cameras or only 10 or 15 minute checks.

Constant monitoring of the individual where the individual's face is visible at all times is the expected standard in order to observe distress or problems. One to one, face to face monitoring is fast becoming standard practice. This also includes following CMS and JCAHO guidelines as to bathroom breaks, food and fluids, range of motion and extremity checks.

Questions to ask?

- 1) How often was the individual monitored?
- 2) Was the individual restrained in a prone or supine position and why?
- 3) Was agency policy followed and documented?
- 4) Was the hospital's policy and procedure followed?

Step 9: Was the individual released ASAP (or not)?

Decisions on when to release a person from seclusion or restraint often requires the judgment of an experienced staff person who is well trained in the physical and emotional risks inherent in S/R use on human beings, has a thorough knowledge of human behavior, and good clinical judgment. In general, individuals (adults or children) who are currently in seclusion or restraint should not have to "jump through hoops to prove" they can be released. Release criteria should mostly be the responsibility of staff and their assessment of regained control. Usually simple questions such as "How are you doing?" "Do you think you can come out yet?", "Are you able to be released and not hurt yourself or anyone?" are sufficient to assess readiness. Again, for individuals who are unknown or who have histories of intentional violence need to be carefully assessed. For persons who fall asleep, best practice calls for restraints to be released or seclusion doors to be opened but with continued face-to-face observation until person awakes and can be assessed. Hospital policy that expects release in 2-4 hours or less can help staff facilitate release in a timely manner.

Questions to ask?

- 1) When was the individual released?
- 2) Who made the decision and what was it based on?
- 3) Was policy followed?

- 4) Could the individual have been released earlier?
- 5) Was release too soon and why?
- 6) What were the documented release criteria were they used and were they appropriate?

Step 10: Did Post-event activities occur (or not)?

This step relates to the agencies debriefing processes. The first, described above, is the immediate acute event response by a supervisor or senior clinical staff member. Goals for the post acute (immediate) response include assuring;

- the safety of the individual, the staff and the witnesses to the event;
- that the documentation is accurate and meets the agency standard;
- that information required to inform a formal debriefing is gathered in real time by a person uninvolved in the incident;
- that the milieu is returned to pre-crisis levels

Also included here is the occurrence of a formal debriefing in a timely, rigorous, problem solving, and stepwise process designed to elicit performance improvement ideas and activities. The formal acute and formal debrief activities need to be documented and filed.

Questions to ask?

- 1) Did the acute response to the event and formal debriefing occur and what were the timelines?
- 2) Who led the acute response and were they uninvolved in the event?
- 3) Was this documented and what happened to the findings?
- 4) Did the findings inform the formal debriefing or practices in general?
- 5) Is the formal debriefing documented as to processes and results and where does that go?
- 6) Were consumer staff or advocates involved in the debriefing process?
- 7) Did the person attend the formal debriefing or did the person agree to be interviewed by a peer staff person?

Step 11: Did learning occur and was it integrated into the treatment plan and practice (or not)?

The integrity of the debriefing process can be measured by the learning that occurs and the changes, revisions, additions, deletions that can be tracked in operational procedures. This debriefing process is a continuous quality improvement process that results in learning from mistakes and crafting new responses including policy and procedure changes, individual treatment plan and de-escalation plan revisions, training and education, individual staff counseling, values clarification, operational rule evaluation and other like events.

Questions to ask?

- 1) What was learned about the S/R event in the debriefing process?
- 2) Did this learning inform policy, practices, procedures, rules, the treatment plan, staff training and education, unit rules?
- 3) Did staff receive training and education or counseling?

Note: This debriefing policy and procedure is to be used as a guide. Toward that end it is probably longer and includes more detail than most policy and procedures. Hospitals and facilities will need to adapt their individual procedure to meet their needs and capabilities. For facilities that are using frequent holds and cannot perform this level of debriefing on every incident, it is recommended that the S/R reduction team determine what frequency or individual characteristics will be put into policy to trigger this level of review. For instance, any child who receives more than three holds a week, any event that results in an injury or a

pattern of outlier use by a unit, individual staff member that may indicate additional training needs.

Source: National Association of State Mental Health Program Directors (2008). Six Core Strategies for Reducing Seclusion and Restraint Use. Alexandria, VA: NASMHPD.